Kentucky WIC Program
Retailer/Drug Store Application

Please print unless otherwise indicated.

All questions on the application must be properly and fully completed. Please review the Kentucky WIC Manual for Applying Retailers for instructions on completing this form. Incomplete applications will be denied.

STORE IDENTIFICATION

1. Store name: _____ Tax ID #: _____
2. Physical address:

   Street address/rural route number: _____

   City: _____

   County: _____ State: _____ Zip: _____

   Store telephone number: _____ Fax: _____

   E-mail address for store contact: _____
3. Mailing address – complete only if mail cannot be delivered to the physical address.

   Street address/rural route number: _____

   P.O. Box: _____ City: _____ State: _____ Zip: _____

STORE OWNERSHIP AND MANAGEMENT

4. Type of ownership (check one):

   ☐ Major Chain – Multiple States

   ☐ Independent Chain – Local Corporate Ownership

   ☐ Franchise – Multiple Locations ☐ Franchise – Single Location

   ☐ Independent – Not a Franchise ☐ Commissary

How many stores are under the same ownership? (Include applying store) _____

How many of these stores are currently authorized for the KY WIC Program? _____

How many of these stores are currently authorized for the Food Stamp Program? _____

5. **Corporate Identification - name and address of corporation:**
(Parent corp., if store is company owned)

Corporate contact name: _____

Business name: _____

Street number: _____ Street_____

City/State/Zip: _____

E-mail of corporate contact: _____

6. **Owner/Corporate Officer:**

Owner's/officer's address - enter requested information for owners of sole proprietorships, partnerships, principal shareholders of private corporations, LLC members or officers of a corporation. Include spouses in community property. If more than two owners, attach to this application the same information for each owner:

Present exactly as shown on legal documents.

First and Last Name: _____ Social Security #: _____

Street number: _____ Street/P.O. Box: _____

City/State/Zip: _____ Phone: _____

E-mail address: _____

First and Last Name: _____ Social Security #: _____

Street number: _____ Street/P.O. Box: _____

City/State/Zip: _____ Phone: _____

E-mail address: _____

Privacy Act Statement: The collection of the social security number (SSN) is authorized by Section 2018 of Title 7, US Code and will be used to determine whether a store qualifies to participate in the WIC program, to monitor compliance with program regulations and for program management. The provision of the SSNs will be available only to officers and employees whose duties or responsibilities require access for the administration or enforcement of the Special Supplemental Nutrition Program for Women, Infants and Children (WIC program) and the Food Stamp Act.

7. **Store Manager Identification** - person with primary on-site responsibility for daily operations:

   First and last name: _____

   E-mail address: _____ Fax #: _____

8. Business Ethics: Are any of the following now charged with or have they ever been convicted of or had a civil judgment for fraud; antitrust violation; embezzlement, theft or forgery; bribery; falsification or destruction of records; making false statements or claims; receiving stolen property; or obstruction of justice: 1) any partner, 2) owner, 3) any officer, 4) the corporate entity, 5) the manager or 6) any stockholder who has a substantial role in the operation of the store?

   ☐Yes ☐No

   If yes, attach a written explanation, giving the name of the person(s) charged or convicted and their relationship to the owner, partner or corporate entity and their current or past position, if any, in the store or corporation; the court and court docket number, the crime(s) and date(s) committed; the penalty and time served and any other relevant information.

9. Are you (applying owner) related to the previous owner? ☐Yes ☐No

   If yes, what is the relationship? _____

10. Have you (applying owner) ever previously applied to participate in the WIC Program and had your application rejected? ☐ Yes ☐No

    If yes, list date and reason rejected: _____

11. Have you ever previously participated in the WIC Program? ☐ Yes ☐ No

    If yes, name of store: _____ Address: _____

    WIC vendor number: _____ Dates of participation: _____

12. Have you, the corporation or the manager ever owned, managed or been an employee of a firm which received a warning, disqualification or termination from the WIC Program? ☐ Yes ☐No If yes, enter:

    Store name and address: _____

    Person/entity involved: _____

    (Attached a listing of vendor numbers and store names if more than one (1) store.)

    Type of action received:

    ☐ Warning ☐ Disqualification ☐ Termination Effective date: _____

    Reason: _____

    _____

13. Previous Store Name and Owner:

    Name: _____ Owner: _____

STORE OPERATIONS AND SALES

14. When did (or will) the store open for business under the applying ownership?

    _____ _____ _____
    Month Day Year

15. What hours is the store open? Example: M – F 7a.m. to 11p.m.; Sat – Sun 7a.m. to 12a.m.

    _____

16. Is this store open year-round, AT LEAST 40 hours a week? ☐ Yes ☐ No

17. Is this store's name visible on the outside of the store? ☐ Yes ☐ No

    If no, indicate name on sign or store front if different than name on the front of this application: _____

18. Indicate the number of cash registers: _____

19. Can this store accept WIC Program benefits electronically? ☐ Yes ☐ No

    This may be done by using the store's own multifunctional equipment or through use of a separate internet access device that transacts only WIC EBT redemptions.

20. Will the store use an FNS certified integrated system? ☐ Yes ☐ No

21. Does the store have an internet or telephone connection? If yes, what type?

    ☐ Yes ☐ No _____

22. List the internet or telephone service provider for this store. _____

23. Does the store's system have a firewall? ☐ Yes ☐ No

24. Does the store's system use a dynamic host configuration protocol (DHCP)?

    ☐ Yes ☐ No

25. Does the store's system use static IP addresses? If yes, what are the IP addresses or range of IP addresses? ☐ Yes ☐ No _____

26. Is there a network or telephone drop/jack near the cash registers?

    ☐ Yes ☐ No If no, indicate the location: _____

27. Please provide technical point of contact for the store:

    Contact name: _____ Cell phone: _____

    Office phone: _____ Email address: _____

28. Are there additional electrical outlets available in the lane(s)? ☐ Yes ☐ No

29. Do you expect to derive more than 50% of food sales in WIC? ☐ Yes ☐ No

30. Is there a valid retail-food establishment or retail food store number in the owner's name? ☐Yes ☐ No

    If yes, enter Retail-Food Establishment Number: _____

31. Is this store authorized to accept SNAP? ☐Yes ☐ No ☐ Applied

    If authorized, enter SNAP authorization number: _____

32. Has this store ever been denied, withdrawn, or disqualified from SNAP?

    ☐Yes ☐ No

    If yes, enter date and the reason: _____

33. Has this store ever received a civil money penalty from SNAP? ☐Yes ☐ No

    If yes, enter date and the reason: _____

34. Is there a pharmacy located within the confines of the store? ☐Yes ☐ No

    If yes, will the pharmacy provide exempt formula or WIC eligible medical foods for the WIC Program? ☐Yes ☐ No

35. If applying as a pharmacy, can the store provide exempt formula or WIC eligible medical foods within 48 hours of request? ☐Yes ☐ No

36. List supplier from whom WIC foods are purchased:

    Name: _____

    Street number: _____ Street name: _____

    City/State/Zip: _____ Phone: _____

37. List supplier from whom infant formula is purchased. Infant formula must be purchased from the list of infant formula wholesalers, distributors and retailers licensed in Kentucky or formula manufacturers registered with the FDA. An approved list is available from the State Agency or on-line at http://chfs.ky.gov/dph/mch/ns/WIC.htm

    Name: _____

    Street number: _____ Street name: _____

    City/State/Zip: _____ Phone: _____

STATEMENTS AND CERTIFICATION

Certification and signature of owners (or person who has the ability to apply on behalf of the store or proxy).

I am applying for authorization for this store to take part in the WIC Program, and I have authority to enter into a WIC vendor agreement.

I understand the prices for the WIC approved foods shall be competitive with and not exceed the average shelf price of other vendors in the same peer group.

I understand that my stock of WIC approved foods must meet the WIC Program requirements for minimum variety and quantity at the time of application as a WIC vendor and throughout the period for which the WIC Vendor Agreement shall be in effect.

I understand that my authorization as a WIC vendor is subject to having a current Retail-Food Establishment or Retail Food Store number and a SNAP number.

I understand that the ownership and management of this store will be responsible for understanding the requirements, policies and procedures of the WIC Program and attending required WIC training.

I certify that the information supplied by me on this application and the attached Price List is correct. If it is determined that the information supplied is not correct or that, in review of the information supplied, the State Agency finds that my store does not meet the criteria to be a WIC vendor, my store will not be approved for a contract.

I understand that this is only a request for authorization and does not constitute a contract, and I will not accept WIC benefits until I have received an approved WIC vendor agreement, an authorized WIC vendor stamp, and an XAC device (if applicable).

Note: If this is a **cost plus 10% store**, the final price (WIC price) must be posted on the shelf or on signage in aisle.

Note: Only applies to drugstores - I understand that I am to supply only exempt formula or medical foods as requested.

Signature: _____ Date: _____

Print name: _____ Title: _____

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LOCAL AGENCY USE ONLY

1. Complete the following by: (a) checking yes if the store meets both the "inventory specifications" and "total quantity required in stock," or no if the vendor does not meet the criteria; and (b) checking yes if the store has the prices for food items displayed on the shelf, food item or display case or no if the prices are not clearly displayed. The following information must be obtained during an on-site visit. The on-site visit cannot be performed until the applying owner has actually taken possession of the store and the property transfer has been completed.

   Note: this portion of inventory pricing is not applicable for drug/pharmacy.

FOOD ITEM	INVENTORY SPECIFICATIONS	TOTAL QUANTITY REQUIRED IN STOCK	INVENTORY IN STOCK	COMMENTS	PRICES MARKED
MILK	2 TYPES REQUIRED MUST HAVE WHOLE MILK AND ONE OF EITHER REDUCED FAT, SKIM OR LOW FAT MILK IN GALLON CONTAINERS; MUST BE ABLE TO SUPPLY ½ GALLONS AND QUARTS UPON REQUEST	4 - GALLONS WHOLE AND 10 - GALLONS LOWFAT	☐ YES ☐ NO		☐ YES ☐ NO
CHEESE	1 TYPE REQUIRED MUST BE AVAILABLE IN 8 OUNCE AND 16 OUNCE PACKAGES; NO DELI CHEESE OF ANY TYPE	4 - POUNDS	☐ YES ☐ NO		☐ YES ☐ NO
EGGS	GRADE A LARGE OR SMALLER	5 - DOZEN	☐ YES ☐ NO		☐ YES ☐ NO
CEREAL	3 PRODUCTS 2 OF THE 3 PRODUCTS MUST BE WHOLE GRAIN	9 - BOXES	☐ YES ☐ NO		☐ YES ☐ NO
JUICE	2 FLAVORS OF 64 OUNCE AND 2 FLAVORS OF 46 OR 48 OUNCE REQUIRED MUST BE 100% FRUIT OR VEGETABLE JUICE, UNSWEETENED	COMBINED QUANTITIES TO EQUAL 14 CONTAINERS	☐ YES ☐ NO		☐ YES ☐ NO

BEANS OR PEAS	1 TYPE DRY BEANS OR PEAS AND 1 TYPE CANNED BEANS OR PEAS	4 - ONE POUND PACKAGES AND 16 - 15 TO 16 OUNCE CANS	☐YES ☐ NO		☐YES ☐ NO
FISH	1 TYPE REQUIRED	45 - OUNCES	☐YES ☐ NO		☐YES ☐ NO
PEANUT BUTTER	1 TYPE REQUIRED	4 – 16 OR 18 OUNCE CONTAINERS	☐YES ☐ NO		☐YES ☐ NO
WHOLE WHEAT BREAD OR OTHER WHOLE GRAINS	1 TYPE REQUIRED BREAD, RICE OR TORTILLA	4 - 16 OUNCE PACKAGES OF BREAD OR TORTILLAS OR 14 OR 16 OUNCE PACKAGES OF RICE	☐YES ☐ NO		☐YES ☐ NO
FRESH FRUITS & VEGETABLES	2 TYPES FRESH FRUITS AND 2 TYPES FRESH VEGETABLES	10 - POUNDS TOTAL	☐YES ☐ NO		☐YES ☐ NO
INFANT FORMULA	1 TYPE OF CONTRACT BRAND POWDER REQUIRED GERBER GOOD START GENTLE, GOOD START PROTECT, GOOD START SOY, GOOD START SOOTHE	11 - CANS TOTAL OF CONTRACT BRAND POWDERED FORMULAS	☐YES ☐ NO		☐YES ☐ NO
INFANT CEREAL	1 TYPE REQUIRED 8 OUNCE CONTAINERS	3 - CONTAINERS TOTAL	☐YES ☐ NO		☐YES ☐ NO
INFANT FRUITS & VEGETABLES	2 TYPES INFANT FRUITS AND 2 TYPES INFANT VEGETABLES JARS ONLY	32 - 4 OUNCE JARS	☐YES ☐ NO		☐YES ☐ NO

2. Are the store's prices the same as the prices on the price list? ☐Yes ☐ No

   If no, explain: _____

3. Is this store primarily a retail grocery? ☐Yes ☐ No

   If no, explain: _____

   Indicate staple food items sold at this store (must stock at least two selections in each of the following four staple food groups):

bread/cereal	dairy products	fruits/vegetables	meat, poultry, fish
☐ bread	☐ milk	☐ fresh fruits/ vegetables	☐ beef/chicken
☐ cereal	☐ cheese	☐ canned fruits/ vegetables	☐ pork/bacon/ham
☐ pasta	☐ butter	☐ frozen fruits/ vegetables	☐ eggs
☐ rice	☐ yogurt	☐ 100% fruit/ vegetable juices	☐ lunch meats/ hot dogs
☐ flour	☐ other_____	☐ other_____	☐ other_____

   Indicate other items sold at this store: ☐ gasoline ☐ lottery tickets

   ☐ liquor ☐ auto parts ☐ hardware ☐ video rental ☐ deli ☐ bait

4. Have you reviewed with this store the Vendor Agreement and the consequences of Program abuse? ☐Yes ☐ No

5. Has the vendor applicant been warned that he/she is not an authorized WIC vendor and cannot accept WIC benefits until the authorized stamp/POS device is obtained? ☐Yes ☐ No

LOCAL AGENCY USE ONLY - VENDOR

The following information must be obtained during an on-site visit. The on-site visit cannot be performed until the applicant has actually taken possession of the store and the property transfer has been completed.

1. Verify the Price List with the shelf or display case prices, if applicable.
2. Warn vendor applicant that he/she is not an Authorized WIC Vendor and cannot accept WIC benefits until the authorized stamp is obtained and initial training completed.
3. I certify that I have visited this store and find it (☐**eligible/**☐**not eligible**) based upon the criteria for selection of vendors and the vendor agreement. if this vendor applicant is not eligible, please document why:

_____

_____

_____

Print legibly the name of Local Agency reviewer

_____ _____

Signature of Local Agency reviewer Date

LOCAL AGENCY USE ONLY – DRUG STORE

The following information must be obtained during an on-site visit. The on-site visit cannot be performed until the applicant has actually taken possession of the store and the property transfer has been completed.

1. Review Drug Store's SRP listing(s). (Does/Do) the SRP listing(s) have an extensive list of formula?

   ☐Yes ☐ No

2. Verify the Price List with the shelf or display case prices, if applicable.
3. Warn vendor applicant that he/she is not an Authorized WIC Vendor and cannot accept WIC benefits until the authorized stamp is obtained and initial training completed.
4. I certify that I have visited this store and find it (☐**eligible/**☐**not eligible**) based upon the criteria for selection of drug stores and the vendor agreement. if this vendor applicant is not eligible, please document why:

_____

_____

_____

Print legibly the name of Local Agency reviewer

_____ _____

Signature of Local Agency reviewer Date

STATE AGENCY USE ONLY

1. Are the food prices competitive? ☐Yes ☐ No

2. SNAP Number: _____ Date verified: _____

3. Retail-Food Establishment Number: _____ Date verified: _____

4. Has the fifty percent (50%) criterion assessment been completed? ☐Yes ☐ No

5. Does the vendor meet the criteria for selection of vendors? ☐Yes ☐ No
   If no, explain: _____
   _____

6. Has request been sent to CDP for eWIC approval? ☐Yes ☐ No

7. Recommended for approval? ☐Yes ☐ No

_____ _____
Signature of State Agency reviewer Date